Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Last updated: 02/03/05

Colposcopy Chart Form

Date: _____

G _____P _____Age: _____

LMP: _____

BCM: _____

Age 1st Coitus: _____

Lifetime Sex Partners: _____

DES exposure: _____

STD Hx: _____

External HPV: _____

Smoking Hx: _____

Pre Meds: _____

Consent signed? ❑ Yes ❑ No

Age when first pap: _____

Age when first abnormal pap: _____

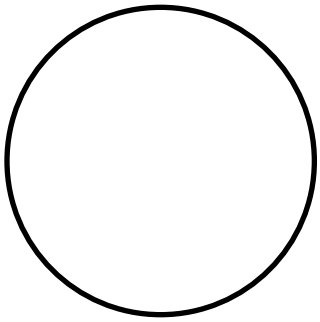
What year cryo, LEEP, or other treatment done: _____

Results and dates of last 3 pap smears: _____

Results and dates of prior colposcopy exams: _____

_____

W = aceto white
P = punctation
M = mosaic
V = abnl vessels



Pap ____
GC ____

CT ____

Examination

Gross Lesion: ❑ Yes ❑ No
Adequate: ❑ Yes ❑ No
❑ Yes with speculum
ECC: ❑ Yes ❑ No
Pap collected: ❑ Yes ❑ No
Biopsies #: _____

Imp: _____

_____

Plan

_____

_____

_____

Counseling

_____Stop smoking
_____Importance of follow-up
_____Nothing in vagina x 3 days

If treatment needed would cryo probe be adequate? ❑ Yes ❑ No

_____
Signature

Pathology Review/Patient Contact

Results:
Pap: _____

ECC: _____

Biopsy: _____

Plan: ❑ Pap F/U ❑ Refer for treatment ❑ Refer for further evaluation ❑ Other
❑ Pap in one year ❑ If persists RTC for colpo

Signature Date

Place Patient Information Sticker Here

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Xerox with Procedure Consent on reverse side

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Consultation/Referral Request

Client Name: _____

Interpreter needed? ❑ YES ❑ NO Language: _____

Client phone number (provide enough information to facilitate contact): _____

_____

Consult/Referral (Whom/Where will be this referral be sent): _____

_____

Reason for Consultation/Referral:

_____

_____

_____

_____

Please send a written report of the consultation to the following provider at the indicated address:

_____ _____

Referring Provider (Print Name Legibly) Date

- ❑ **Auburn Public Health Center (206) 296-8400**
  20 Auburn Ave., Auburn, WA 98002
- ❑ **Columbia Public Health Center (206) 296-4650**
  4400-37th Ave. So., Seattle, WA 98118
- ❑ **Downtown Public Health Center (206) 296-4755**
  2124-4th Ave., Seattle, WA 98121
- ❑ **Eastgate Public Health Center (206) 296-4920**
  14350 S.E. Eastgate Way, Bellevue, WA 98007
- ❑ **Federal Way Public Health Center (206) 296-8410**
  33431 13th Place So., Federal Way, WA 98003
- ❑ **Kent Teen Clinic (206) 296-7450**
  613 W. Gowe, Kent, WA 98032
- ❑ **North Public Health Center (206) 296-4765**
  10501 Meridian Ave. North, Seattle, WA 98133
- ❑ **Northshore Public Health Center (206) 296-9787**
  10808 N.E. 145th Street, Bothell, WA 98011
- ❑ **Renton Public Health Center (206) 296-4700**
  3001 N.E. 4th, Renton, WA 98056
- ❑ **White Center Public Health Center (206) 296-4620**
  10821-8th Ave. S.W., Seattle, WA 98146

Place Patient Information Sticker Here
OR Name & DOB

CS 13.22.95, 450-0024
Last updated: 06/07/02

Contraceptive Implant Insertion or Removal Procedure Chart Form

Age: _____ G: _____ P: _____ LMP: _____ Current Contraception: _____ Any UPIC? _____
Date of Last Delivery: _____ Lactation: ❑ Yes ❑ No Plans future children? ❑ Yes ❑ No

Both Insertion and Removal Procedures:

- ❑ PHSKC FP Implant Insertion Procedure Consent Form signed and all questions answered.
- ❑ Counseled about procedure and is aware of possible difficult removal including a possible second procedure if Norplant.
- ❑ Advised of potential arm scarring, bruising, pain, swelling, hyperpigmentation, possibility of seeing the implants, and sometimes asymmetric or crooked implants.

❑ **Insertions:**

- ❑ Has documented pap/breast exam within past 12 months.
- ❑ Counseling about decision, risks, side-effects and benefits discussed.
- ❑ Documented to have no allergy to lidocaine, betadine, or tape.
- ❑ Is aware of irregular menstrual bleeding including amenorrhea with method and still wants method.
- ❑ Is aware implant does not provide protection against STD infections.
- ❑ No contraindications to method.
- ❑ No pregnancy or risk of pregnancy at the time of insertion.

Reason for choosing contraceptive implant: _____

Plans for back-up contraception if needed: _____

❑ **Removals:**

Reason for contraceptive implant removal: _____

- ❑ Plans for contraception after removal made.

Operative Report: *(check one)*: ❑ Insertion ❑ Removal
Type of implant system: ❑ Norplant ❑ Jadelle ❑ Implanon Lot #: _____ Expiration date: _____
BP_____ pulse _____ Weight _____ HCG test performed for insertion and result: _____

The ventromedial surface of the non-dominant _____ arm was cleansed with ρ betadine or ρ chlorhexidine *(check one)* and a sterile field created. Lidocaine 1% _____ mL with epinephrine 1:100,000 was injected intradermally into the planned incision site for insertion. For removal anesthesia: check either infiltrated ❑ under the implants or ❑ proximal to the implants.
Implants removed or inserted according to the implant system protocol.
_____ implants (put in number) removed or inserted *(circle one)*. Time for removal: _____.
Site steri-stripped and compression dressing applied. Procedure tolerated _____.
If insertion, implants palpable at the end of the procedure ❑ yes ❑ no. ❑ Complications none, or describe below:

If removal, all implants shown to client and if inserted, all implants palpated by client: ❑ yes ❑ no.

- ❑ Aware of need for backup method for 1 week if not inserted cycle day less than day 5.
- ❑ Follow-up appointment made, including repeat HCG test if appropriate.
- ❑ Patient education sheet/package insert given to client.
- ❑ Advised to call if fever or signs of infection.
- ❑ Advised, date system will no longer be effective: _____
- ❑ Contraception plan made if back-up needed or if removed: _____
- ❑ Prescription for NSAIDS given: _____
- ❑ Chart labeled with Do Not Purge Sticker to retain records for 10 years. ❑ Interpreter present for visit.

Signature/Title:_____Date:

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Xerox with consent on back

Place Patient Information Sticker Here

EDUCATION COUNSELING RISK REDUCTION (ECRR) FLOW SHEET

Date Initiated Date Completed (if all items addressed on one day)	____/____/____ ____/____/____	____/____/____ ____/____/____	____/____/____ ____/____/____	____/____/____ ____/____/____	____/____/____ ____/____/____
a) Did you help the client (female or male) critically evaluate which contraceptive method was most acceptable and could be used most effectively by her/him?	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______
b) If the client planned no method, did you give preconception counseling?	❑ Yes ❑ No ❑ NA Date ___/___/___ Initials ______	❑ Yes ❑ No ❑ NA Date ___/___/___ Initials ______	❑ Yes ❑ No ❑ NA Date ___/___/___ Initials ______	❑ Yes ❑ No ❑ NA Date ___/___/___ Initials ______	❑ Yes ❑ No ❑ NA Date ___/___/___ Initials ______
c) Did you discuss back-up methods with the client and provide ECP access?	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______
d) Did you evaluate and address the client's personal considerations that could impact the use of contraceptive method(s)?	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______
e) Did you make a follow-up appointment, as appropriate to the method?	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______
f) For male clients, (in addition to above), did you discuss the male role in supporting his partner's successful use of chosen contraception and prevention of unintended pregnancy?	❑ Yes ❑ No ❑ NA Date ___/___/___ Initials ______	❑ Yes ❑ No ❑ NA Date ___/___/___ Initials ______	❑ Yes ❑ No ❑ NA Date ___/___/___ Initials ______	❑ Yes ❑ No ❑ NA Date ___/___/___ Initials ______	❑ Yes ❑ No ❑ NA Date ___/___/___ Initials ______
g) Encounter submitted	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______	❑ Yes ❑ No Date ___/___/___ Initials ______

____________	____	____________	____	____________	____
____________	____	____________	____	____________	____
____________	____	____________	____	____________	____
Signature	Initials	Signature	Initials	Signature	Initials

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Name ____________________________
Last, First, Middle, Maiden

B.D. __________ Patient I.D. ________________

Emergency Contraception Verbal Order Chart Form

S: AGE _____ G _____ P _____ AB _____ Lactating ❑ Yes ❑ No

1. Current BCM:
   Desires pregnancy ❑ No ❑ Yes (do not give ECP) Allergies_____
   Regular Medications:_____
2. Reason for ECP
   - ❑ Possible future need because of future birth control method failure
   - ❑ Emergent need (complete #3 below): ❑ condom broke ❑ missed OCPs ❑ method not used correctly ❑ no method used ❑ other: _____
3. LMP _____ LNMP _____ Cycle day since LMP when first UPIC occurred: _____
   Coital Hx: Hours since UPIC <24 ❑ 24-48 ❑ 49-72 ❑ 73-120 ❑ >120 (not effective)
   Multiple UPIC ❑ No ❑ Yes

O: UCG (optional): ❑ Negative ❑ Positive ❑ Not indicated (no UPIC >14 days) ❑ Not indicated, pregnant seeking TOP and ECP for use after abortion

Blood Pressure (optional): _____

A: Candidate for ECP: ❑ No ❑ Yes, ❑ Emergent Need and/or ❑ Future Possible Need

P: TELEPHONE PRESCRIPTION OBTAINED FROM: Provider _____ Date_____ Time_____

Denied prescription and reason: _____

- ❑ Prescription to be batched and given to provider _____ Date_____
- ❑ Levonorgestrel 750 mcg pill, one po STAT and then repeat in exactly 12 hours
- ❑ Levonorgestrel 750 mcg pill, two pills po STAT now because the client prefers single dose rather than divided dose timing of the Lng ECP (this option can not be used for Yutzpe or combination OCP ECP).
- ❑ Plan B not available so combination OCP prescribed per guidelines, specifically: _____
- ❑ Two Levonorgestrel 750 mcg pills for future use, to take one, and repeat in 12 hours, within 120 hours following future UPIC or method failure (only one package for future use is to be dispensed at a time).

COUNSELING PROVIDED:

- ❑ ECP risk, benefits and side effects discussed
- ❑ Advised to call if vomits 2 hours from ingestion (< 5% risk of this) to call and needs to repeat both pill doses.
- ❑ Advised to call when ECP used in the future for a clinic appointment
- ❑ Follow-up telephone call within 24 hours (if emergent use of estrogen ECP)
- ❑ 2 week follow-up phone call or letter (if emergent use and refused or did not keep clinic appt)
- ❑ 2-week follow-up appointment scheduled at_____ clinic
- ❑ Birth control plan discussed and contraception method desired: _____
- ❑ If contraceptive method requires prescription then appointment scheduled in PHSKC clinic _____(site) in 1-2 weeks for exam and provider visit or reason not done: _____

NOTES: _____

_____

_____

PHN Signature _____ **Date** _____

Send chart with completed form for provider signature within 2 weeks and keep copy of this form for follow-up.
I gave the above verbal prescription as described:

Provider Signature _____ **Date** _____

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Last updated: 12/20/02

Endometrial Biopsy Procedure Chart Form

Age: _____ G: _____ P: _____ LMP: _____ Last Pap Date:_____Results:_____
Current Contraception: _____ Date of last delivery: _____
History of abnormal uterine bleeding: _____
❑ Past/current treatment _____
History of: ❑ Pelvic infection, ❑ STD _____, ❑ Fibroid, ❑ Thyroid disorder, ❑ Other_____
Prior EMB, D&C, TVS: Date:_____ Results_____ HCG_____ ❑ Not done
Single current partner of what duration: _____ years _____ months

Reason for EMB:

❑ Abnormal uterine bleeding
❑ Post-menopausal bleeding
❑ Prior endometrial hyperplasia
❑ Amenorrhea
❑ Unopposed estrogen therapy
❑ Hereditary nonpolyposis colon cancer
❑ Tamoxifen therapy
❑ Endometrial cells on pap and post-menopausal
❑ Infertility evaluation
❑ _____

Accepts possible risks:

❑ Cramping pain during procedure and 1-2 days after procedure
❑ Bleeding, (may occur for several days after procedure)
❑ Infection
❑ Perforation of uterus
❑ Allergic reaction to medications or instruments used
❑ Vasovagal reaction
❑ Disruption of unknown pregnancy
❑ Missed abnormal tissue

Procedure Note:

❑ PHSKC Informed Consent for EMB signed and placed in chart
❑ Denies allergy to ❑ betadine, ❑ lidocaine, ❑ benzocaine latex, ❑ _____
Premedication;_____
Bimanual exam results: ❑ AV/AF ❑ midline ❑ RV/RF ❑ small, firm, non-pregnant, symmetric ❑ other: _____
Cervical os cleaned with: ❑ betadine ❑ _____ ❑ BP_____ ❑ Pulse _____
Tenaculum placed on cervix: ❑ Anterior ❑ Posterior ❑ Not done
❑ 20% benzocaine applied to cervix ❑ 1% lidocaine paracervical injection
Sounded uterine depth: _____ ❑ NA:
Type of endometrial catheter: ❑ Pipelle ρ Other_____
❑ Endometrial catheter easily passed through internal os or _____
❑ Endometrial catheter placed to fundus, suction created; endometrial tissue ❑ scant, ❑ adequate, ❑_____
❑ Collected tissue placed in formalin
❑ Tenaculum removed, hemostasis confirmed ❑ NA
❑ Tolerated procedure well
❑ No complications, or _____
❑ Given advice to: ❑ call for fever, excess bleeding or pain.
❑ pelvic rest for 3 days
❑ NSAIDS post procedure if needed
❑ F/U post-procedure to discuss EMB pathology results

NOTES:

_____ ❑ Interpreter present and assisted with visit
MA\RN Provider Signature/Title Date

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here

FEMALE FAMILY PLANNING / STD VISIT FORM

CC: _____

_____

Visit Date: _____
G _____ P _____ # LC _____
Age _____ BP _____ Wt _____
Temp _____ Pulse _____ Ht _____
Annual Exam Due: _____
Last Pap: _____ Result: _____

Housing Status: _____

Tobacco use: _____ Allergies: _____

Meds: _____

HPI: _____

_____

_____

_____

ROS: Constitutional Skin GI GU Breast Neuro CV Resp ENT Eyes Musculoskeletal

_____*Systems reviewed, positive for* _____ *otherwise negative.*

PMH/SH/FH: ❒ reviewed Medical History Form and ❒ no change, or changes per below:

_____

_____

Contraceptive History

LMP _____ Date last pregnancy ended _____ Lactation? ❒ yes ❒ no Desires Pregnancy? ❒ no ❒ yes

Current BCM _____ Used as prescribed? ❒ yes ❒ no, _____

If injection BCM, ❒ N/A, last one given ≤ 13 weeks or ≤ 33 days ❒ yes ❒ no, _____

Amenorrhea? ❒ yes ❒ no Bleeding between periods? ❒ no ❒ yes, _____

Any new symptoms or problems? _____

Any ACHES Sx? ❒ N/A ❒ no ❒ yes, describe: _____

Satisfied with current BCM ❒ yes ❒ no, explain: _____

UPIC past 14 days ❒ no, then Contraceptive Hx complete ❒ yes, describe: _____

UPIC past 5 days ❒ no ❒ yes, wants ECP? ❒ no ❒ yes, _____

Hours since UPIC ❒ <24 ❒ 24-48 ❒ 49-72 ❒ 73-120 (less effective) ❒ >120 (not effective)

UPIC reason: ❒ condom broke or slipped ❒ missed OCPs ❒ no method used ❒ Other: _____

Multiple UPIC ❒ no ❒ yes, still wants ECP and is aware it can fail? ❒ yes ❒ no

STD Concerns ❒ no ❒ yes ❒ n/a

Past STD History _____

Current STD Symptoms _____

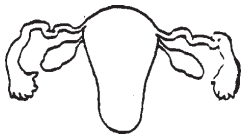
Sx in partners _____ Exposure _____

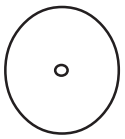
partners/2 months _____ How long with current partner? _____ # lifetime partners? _____

Public Health
Seattle & King County

Chart Label

O:	WNL	ABN	N/A	COMMENTS:
General	❒	❒	❒	
Thyroid	❒	❒	❒	
Breasts	❒	❒	❒	
Heart	❒	❒	❒	
Lungs	❒	❒	❒	
Abdomen	❒	❒	❒	
Skin	❒	❒	❒	
Extremities	❒	❒	❒	
Lymph Nodes	❒	❒	❒	
Pelvic				
Urethra/Bladder	❒	❒	❒	
Vulva	❒	❒	❒	
Vagina	❒	❒	❒	
Discharge	❒	❒	❒	
Cervix	❒	❒	❒	
Uterus	❒	❒	❒	❒ Ant ❒ Post ❒ Mid Size _____
Adnexa	❒	❒	❒	
Anus	❒	❒	❒	
Digital rectal exam	❒	❒	❒	





STAT LABS

❒ UCG neg pos ❒ pH _____ ❒ KOH neg pos ❒ Other: _____

❒ Hct/Hgb _____ ❒ WHIFF neg pos ❒ Saline _____

Assessment: _____

LABS SENT

❒ PAP ❒ GC ❒ RPR ❒ Hep C ❒ Other

❒ CT ❒ HSV ❒ Hep B ❒ Urine Culture

❒ HIV testing requested ❒, or recommended ❒ for client, and client agrees.

OUTSIDE RECORDS

❒ Ordered

❒ Reviewed

COUNSELING AND COORDINATION OF CARE *(If billing by time, _____ minutes provider spent face to face with client.)*

❒ Contraception _____ ❒ Preconception counseling ❒ Calcium/Obesity/Iron

❒ How to start and use the method ❒ ECRR teaching done ❒ Family Involvement / Relationship Safety

❒ Back up method for 7 days ❒ STD/HIV Prevention ❒ Cervical Cytology/HPV

❒ ECP availability/use/side effects ❒ Substance use ❒ Breast self-exam/Screening

❒ Advance provision ECP ❒ Refused ❒ Tobacco Cessation ❒ Other _____

❒ BCM Specific Consent Form ❒ Estrogen side effects and thrombosis danger signs

Contraceptive Management: ❒ no contraindications to method. Risks and benefits discussed. _____

Method/brand: _____ May use for _____ months/cycles, then needs ❒ annual visit, or needs ❒ revisit and if normal visit (❒ with provider) then _____ more months/cycles may be given. ❒ Package insert given.

ECP ❒ Plan B # packs _____ ❒ emergent ❒ advance and ❒ may refill as needed.

Injection: ❒ DMPA ❒ Lunelle ❒ Hep B Site _____ Lot # _____ Signature _____ Next shot due _____

Same day start/restart hormone method or ECP ❒ no ❒ yes, client aware of risk early pregnancy, need to return for HCG in ≤ 4 weeks, and need for back-up method for 7 days.

❒ See Medication Sheet for prescriptions

Plan/Follow-up: _____

_____ / _____

RN/MA/Health Educator Provider Date

(2-hole punch at top of this page only)

FEMALE FAMILY PLANNING HEALTH HISTORY FORM

Please answer the questions below:

Last Name First	Date of birth	Age	Date today

Home phone number ( )	Message/pager number ( )	Best time to call

What is the main reason for your visit today?_____

Are you allergic to any medicines, shellfish, or copper?
❒ **No** ❒ **Yes** *Which ones, what happened?*

Do you take (or are you supposed to take) medicines, natural remedies, aspirin, or other drugs every day?
❒ **No** ❒ **Yes** *List them:*

NO	YES	*Have you ever had or do you have:*	NO	YES	
❒	❒	Diabetes	❒	❒	Problems with your kidneys or bladder
❒	❒	Seizures	❒	❒	Bone disease or weak bones
❒	❒	Heart attacks or strokes	❒	❒	Cancer
❒	❒	High blood pressure	❒	❒	Breast surgery or problems
❒	❒	Depression	❒	❒	Pelvic infection treated in the hospital
❒	❒	Migraines or bad headaches	❒	❒	Uterine fibroids or Ovarian cysts
❒	❒	Blood clot in your blood vessels like the leg or lung	❒	❒	Eczema or bad skin rashes
❒	❒	Hepatitis (turned yellow) or gallbladder problem	❒	❒	Ectopic or tubal pregnancy
❒	❒	Any other serious medical condition, surgery, or hospitalization	❒	❒	Blood transfusions or IV Drug use

Has anyone in your **IMMEDIATE** family *(mother, father, sister, brother, daughter, son, or if your parents are less than 50 give information about other relatives)* had any of the following:

		NO	YES	DO NOT WRITE HERE
Cancer:	Who, what type and at what age found?	❒	❒	_____
Diabetes:	Who and at what age?	❒	❒	_____
Heart Attack:	Who and at what age?	❒	❒	_____
Stroke:	Who and at what age?	❒	❒	_____
Blood clots in blood vessels like the leg or lung?	Who and at what age?	❒	❒	_____

Our services are confidential, however, if you are under the age of 18 and share with us a history of sexual abuse *or rape we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.*

Do you use tobacco? **NO** ❒ **YES** ❒ How much do you use? _____ How many years? _____
Do you drink alcohol? **NO** ❒ **YES** ❒ How often? ❒ daily ❒ weekly ❒ monthly
How many alcoholic drinks do you have at one time? ❒ 1-2 drinks ❒ 3-4 drinks ❒ 5+ drinks

Do you use other drugs (examples: marijuana, cocaine, or IV drugs)? **NO** ❒ **YES** ❒
What do you use? _____ How often? ❒ daily ❒ weekly ❒ monthly

Do you feel safe from violence in your personal relationships? **YES** ❒ **NO** ❒

Have you ever had a sexually transmitted disease or genital infection? **NO** ❒ **YES** ❒
Circle the ones you might have had:

Chlamydia	Gonorrhea	Herpes	Genital Warts	PID	Syphilis
HIV	Bacterial Vaginosis	Trichomonas	Hepatitis B or C	Yeast	

(turn over)

How many different sex partners have you had in the last 12 months? _____

Were your partners *(circle correct answers)*: men women both IV drug users bisexual
a partner with multiple sex partners or at risk for HIV or STD infection

How long have you been with your current sex partner(s)? _____ Age you first had sex _____

What type of sex have you had in the past 2 months? *(circle the types)*

Vaginal Oral Anal Other No Sex

Do you have symptoms of a genital infection? **NO** ❒ **YES** ❒ *(circle the ones you have)*

Discharge	Odor	Itch	Rash
Bumps	Sores	Pain with sex	Bleeding after sex
Burning	Stool or anal problems	Pain with urination	Urgent or frequent urination

Have you used a birth control method before? **NO** ❒ **YES** ❒ *(Circle the types you have used and write in years of use:)*

Pills	Condoms	Diaphragm / Cervical Cap	Implant
IUD	Shot/Depo	Vasectomy/Tubal	Abstinence
Withdrawal	Suppository/Film/Foam	Natural Family Planning/Rhythm	Other
Patch/Ring		Emergency Contraceptive Pills	

What do you use now? _____

List any problems with your current methods:

Have you used birth control pills or injections for more than 5 years? **NO** ❒ **YES** ❒
(this can prevent cancer of the ovaries and uterus)

Are you up to date with your immunizations like Rubella or Hepatitis? **NO** ❒ **YES** ❒ **UNKNOWN** ❒

How old were you when you had your first period? Age: _____

For your most recent period, what was the first day bleeding started? Date: _____

How many days do your periods last? # of days: _____ Do you bleed between periods? ❒ **No** ❒ **Yes**

How many days from the start of one period until the start of the next period? # of days: _____

When was the last time you had sex with a male without birth control? Date: _____

Do you think you could be pregnant today? **NO** ❒ **YES** ❒

Do you ever douche or use genital deodorant sprays, powders or wipes? **NO** ❒ **YES** ❒

Will this be your first pelvic exam today? **NO** ❒ **YES** ❒ Date of your last Pap test: _____

Have your Pap tests been normal? **NO** ❒ **YES** ❒ DES exposure **NO** ❒ **YES** ❒

If you have had an abnormal Pap test, when, where, and what was done? _____

Have you ever been pregnant? **NO** ❒ **YES** ❒ *(If no, you are done)* Are you breastfeeding? **NO** ❒ **YES** ❒

# of pregnancies _____	# of deliveries _____	# of ectopics _____
# of living children _____	# of abortions _____	# of miscarriages _____

If you have been pregnant before, when did your last pregnancy end? Date: _____

When you were pregnant, did you get diabetes? **NO** ❒ **YES** ❒

Have any of your babies been 10 pounds or more? **NO** ❒ **YES** ❒ ❒ no babies

History reviewed by: _____

Date: _____

Public Health
Seattle & King County

FPFEMALEHX.P65
450-0343
CS #13.22.61
6.16.04

Chart Label

HISTORIA MEDICA DE PLANIFICACION FAMILIAR FEMENINA

FEMALE FAMILY PLANNING HEALTH HISTORY FORM

Por favor conteste las preguntas siguientes: *Please answer the questions below:*

Apellido: *Last Name:*	**Nombre** *First*	**Fecha de nacimiento** *Date of birth*	**Edad** *Age*	**Fecha** *Date today*

Número de teléfono en su domicilio *Home phone number*	**Mensaje/número de mensáfono** *Message/pager number*	**Mejor hora para llamarle** *Best time to call*
( )	( )	

¿Cuál es la razón principal de su visita el día de hoy? *What is the main reason for your visit today?*

¿Es usted alérgica a algún medicamento, mariscos o al cobre? ❒ **NO** *NO* ❒ **SI** *YES*

¿A cuáles? ***y describa cómo es la reacción:*** *Are you allergic to any medicines, shellfish, or copper? Which ones and describe what happened.*

¿Toma usted (o supuestamente debe tomar) medicamentos, remedios naturales, aspirina o algún otro medicamento diariamente? ❒ **NO** *NO* ❒ **SI** *YES* **De ser así, por favor indíquelos.**

Do you take (or are you supposed to take) medicines, natural remedies, aspirin, or other drugs every day? List them:

NO *NO*	**SI** *YES*	**¿Alguna vez ha tenido o tiene?:** *Have you ever had or do you have:*	**NO** *NO*	**SI** *YES*	
❒	❒	**Diabetes** *Diabetes*	❒	❒	**Problemas con los riñones o la vejiga** *Problems with your kidneys or bladder*
❒	❒	**Convulsiones** *Seizures*	❒	❒	**Cáncer** *Cancer*
❒	❒	**Ataques al corazón o Derrames cerebrales** *Heart attacks or Strokes*	❒	❒	**Cirugía o problemas con los senos** *Breast surgery or problems*
❒	❒	**Presión sanguínea alta** *High blood pressure*	❒	❒	**Infecciones pélvicas tratadas en un hospital** *Pelvic infection treated in the hospital*
❒	❒	**Depresión** *Depression*	❒	❒	**Fibromas uterinos o Quistes en los ovarios** *Uterine fibroids or Ovarian cysts*
❒	❒	**Migrañas** *Migraines*	❒	❒	**Eczema o sarpullido fuerte de la piel** *Eczema or bad skin rashes*
❒	❒	**Coágulos de sangre en sus vasos sanguíneos como en la pierna o el pulmón** *Blood clot in your blood vessels like the leg or lung*	❒	❒	**Embarazos ectópicos o en las trompas de falopio** *Ectopic or tubal pregnancy*
❒	❒	**Hepatitis (Piel amarilla)** *Hepatitis (turned yellow)*	❒	❒	**Algún otro problema de salud serio** *Any other serious medical condition*
❒	❒	**Transfusiones de sangre o uso de drogas por las venas** *Blood transfusions or IV Drug use*			

¿Alguna vez alguien en su familia CERCANA (madre, padre, hermana, hermano, hija, hijo, o si sus padres tienen menos de 50 años, dé información acerca de otros familiares) ha tenido algo de lo siguiente?:
*Has anyone in your **IMMEDIATE** family (mother, father, sister, brother, daughter, son, or if your parents are less than 50 give information about other relatives) had any of the following*:

		NO *NO*	SI *YES*	NO ESCRIBE AQUI *DO NOT WRITE HERE*
Diabetes *Diabetes*	**¿Quién y a qué edad?** *Who and at what age?*	❒	❒	_____
Ataques al corazón *Heart Attack*	**¿Quién y a qué edad?** *Who and at what age?*	❒	❒	_____
Cáncer: *Cancer*	**¿Quién, qué tipo, y a qué edad fue descubierto?** *Who, what type and at what age found?*	❒	❒	_____
Derrame cerebral *Stroke*	**¿Quién y a qué edad?** *Who and at what age?*	❒	❒	_____
¿Coágulos de sangre en sus vasos sanguíneos como en la pierna o el pulmón? ¿Quién y a qué edad? *Blood clots in blood vessels like the leg or lung? Who and at what age?*		❒	❒	_____

Nuestros servicios son confidenciales, sin embargo, si usted es menor de 18 años y comparte con nosotros historia de abuso sexual o violación nosotros estamos obligados por ley a reportar ésto a los Servicios Protectores de la Niñez. Si usted tiene preguntas acerca de estas leyes, por favor pregunte. *Our services are confidential, however, if you are under the age of 18 and share with us a history of sexual abuse or rape we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.*

¿Utiliza o consume usted tabaco? *Do you use tobacco?* **NO** ❒ *NO* **SI** ❒ *YES* **¿Qué cantidad consume?** _____ *How much do you use?* **¿Por cuántos años?** _____ *How many years?*

¿Toma bebidas alcohólicas? *Do you drink alcohol?* **NO** ❒ *NO* **SI** ❒ *YES* **¿Con qué frecuencia?** *How often?* ❒ **diariamente** *daily* ❒ **semanalmente** *weekly* ❒ **mensualmente** *monthly*

¿Cuántas bebidas se toma al mismo tiempo? *How many alcoholic drinks do you have at one time?*

❒ **1-2 bebidas** *1-2 drinks* ρ **3-4 bebidas** *3-4 drinks* ρ **5+ bebidas** *5+ drinks*

¿Consume usted drogas (ejemplo: marihuana , cocaína o drogas por las venas)? *Do you use other drugs (examples: marijuana, cocaine, or IV Drugs)?* ***NO*** ❒ *NO* **SI** ❒ *YES*

¿Qué es lo que usa? _____ *What do you use?* **¿Con qué frecuencia?** ❒ **Diariamente** *Daily* ❒ **semanalmente** *weekly* ❒ **mensualmente** *monthly*

¿Se siente usted segura y libre de violencia en sus relaciones personales? *Do you feel safe from violence in your personal relationships?* **NO** ❒ *NO* **SI** ❒ *YES*

¿Algúna vez ha tenido una enfermedad transmitida sexualmente o alguna infección genital? *Have you ever had a sexually transmitted disease or genital infection?* **NO** ❒ *NO* **SI** ❒ *YES*

Encierre en un círculo aquellas que posiblemente usted haya tenido: *Circle the ones you might have had:*

Clamidia *Chlamydia* **Gonorrea** *Gonorrhea* **Herpes** *Herpes* **Verrugas genitales** *Genital Warts* **Enfermedad inflamatoria pélvica** *PID* **Sífilis** *Syphilis*

VIH *HIV* **Vaginosis Bacterial** *Bacterial Vaginosis* **Triconomas** *Trichonomas* **Hepatitis B o C** *Hepatitis B or C* **Infecciones producidas por hongos** *Yeast infections*

¿Cúantas parejas sexuales ha tenido en los últimos 12 meses? _____
How many different sex partners have you had in the last 12 months?

Su(s) pareja(s) fueron (encierre en un círculo las respuestas correctas)
Were your partners (circle correct answers):

Hombres *Men* **Mujeres** *women* **Ambos** *both*

Usuarios de drogas por las venas
IV Drug users

Bisexual *Bisexual*

Una pareja con múltiples parejas sexuales
A partner with multiple sex partners

¿Cúanto tiempo tiene con su(s) pareja(s) actual(es)? _____
How long have you been with your current sex partner(s)?

¿Qué tipos de sexo ha tenido en los últimos 12 meses? (encierre en un círculo)
What type of sex have you had in the past 2 months? (circle the types)

Vaginal *Vaginal* **Oral** *Oral* **Anal** *Anal* **Otros** *Other* **Ninguno** *No Sex*

¿Tiene usted síntomas de infección genital? **NO** ❒ **SI** ❒ **(encierre en un círculo)**
Do you have symptoms of a genital infection? *NO* *YES* *(circle the ones you have)*

Desecho vaginal *Discharge* **Olor** *Odor* **Comezón (picazón)** *Itch* **Sarpullido** *Rash*

Bultos *Bumps* **Llagas** *Sores* **Dolor al tener relaciones sexuales** *Pain with sex* **Sangrado después de tener relaciones *sexuales*** *Bleeding after sex*

Ardor (quemazón) *Burning* **Problemas con el ano o las heces fecales** *Stool or anal problems*

Dolor al orinar *Pain with urination* **Orina frecuentemente o con urgencia** *Urgent or frequent urination*

¿Ha usado algún método anticonceptivo anteriormente? *Have you used a birth control method before?* **NO** ❒ **SI** ❒ *NO* *YES*

Haga un círculo alrededor de los tipos que ha usado y escriba cuantos años los usó:
(Circle the types you have used and write in years of use:)

Píldoras *Pills* **Condones** *Condoms* **Diafragma** *Diaphragm* **Implantes** *Norplant* **Dispositivo** *IUD* **Inyección/Depo** *Shot/Depo*

Vasectomía/ligadura de as trompas *Vasectomy/Tubal* **Abstinencia** *Abstinence* **Eyacular fuera de la vagina** *Withdrawal*

Supositorio/sello vaginal/Espuma *Suppository/Film/Foam* **Planificación familiar Natural/Método del Ritmo** *Natural Family Planning/Rhythm* **Otro** *Other*

¿Qué es lo que utiliza ahora? *What do you use now?* _____

¿Tiéne algún problema con su método actual? *List any problems with your current methods:*

¿Alguna vez ha usado píldoras anticonceptivas por más de 5 años? *(ésto puede prevenir el cáncer de los senos y el útero*) *Have you used birth control pills for more than 5 years? (this can prevent cancer of the ovaries and uterus)* **NO** ❒ *NO* **SI** ❒ *Yes*

¿Está usted al día con sus inmunizaciones como la Rubéola o Hepatitis? *Are you up to date with your immunizations like Rubella or Hepatitis?* **NO** ❒ *NO* **SI** ❒ *Yes*

¿Qué edad tenía usted cuando tuvo su primera menstruación? *How old were you when you had your first period?* **Edad:** *Age:* _____

¿En su menstruación más reciente, cuál fue el primer día que comenzó a sangrar? *For your most recent period, what was the first day bleeding started?* **Fecha:** *Date:*_____

¿Cuántos días le duran sus menstruaciones? *How many days do your periods last?* **# de días:** *# of days:*_____

¿Cuántos días pasan desde el principio de una menstruación hasta el comienzo de la siguiente? *How many days from the start of one period until the start of the next period?* **# de días:** *# of days:*_____

¿Cuándo fue la última vez que tuvo relaciones sexuales con un hombre sin usar algún método anticonceptivo? *When was the last time you had sex with a male without birth control?* **Fecha:** *Date:*_____

¿Piensa que podría estar embarazada ahora? *Do you think you could be pregnant today?* **NO** ❒ *NO* **SI** ❒ *YES*

¿Se hace lavado vaginal o usa desodorantes vaginales en aerosol, talcos o paños? *Do you ever douche or use genital deodorant sprays, powders or wipes?* **NO** ❒ *NO* **SI** ❒ *YES*

¿Va a ser éste su primer exámen pélvico el día de hoy? *Will this be your first pelvic exam today?* **NO** ❒ *NO* **SI** ❒ *YES* **Fecha de su último Papanicolau:** *Date of your last Pap test:*

¿Han sido sus pruebas de Papanicolau siempre normales? *Have your Pap tests been normal?* **NO** ❒ *NO* **SI** ❒ *YES*

Si alguna vez tuvo una prueba anormal de Papanicolau, diga cuándo, en dónde y qué se hizo al respecto?
If you have had an abnormal Pap test, when, where, and what was done?

¿Ha estado usted embarazada alguna vez? *Have you ever been pregnant?* **NO** ❒ *NO* **SI** ❒ *YES* **(si contestó NO, usted no tiene que seguir con este cuestionario)** *(If no, you are done)*

 # de embarazos _____ *# of pregnancies*

 # de partos _____ *# of deliveries*

 # de hijos vivos _____ *# of living children*

 # de abortos inducidos _____ *# of abortions*

 # de abortos espontáneos _____ *# of miscarriages*

Si usted ha estado embarazada anteriormente ¿cuándo terminó su último embarazo? *If you have been pregnant before, when did your last pregnancy end?* **Fecha:** *Date:*_____

¿Tuvo diabetes cuando usted estaba embarazada? *When you were pregnant, did you get diabetes?* **NO** ❒ *NO* **SI** ❒ *YES*

¿Alguno de sus bebés ha nacido pesando 10 libras o más? *Have any of your babies been 10 pounds or more?* **NO** ❒ *NO* **SI** ❒ *YES* ❒ **ningún bebé** *no babies*

NOTES: _____

_____

_____

_____

_____

_____

_____

_____

Historia revisada por: _____
History reviewed by:

Fecha: *Date:* _____

Chart Label

FAMILY PLANNING FLOW SHEET

Date of Visit							
Annual Visit	❑	❑	❑	❑	❑	❑	❑
Ht. Wt.							
BP							
BC Method							
LABORATORY # Dispensed							
LABORATORY HCT/Hgb	❑	❑	❑	❑	❑	❑	❑
LABORATORY PAP	❑	❑	❑	❑	❑	❑	❑
LABORATORY GC	❑	❑	❑	❑	❑	❑	❑
LABORATORY CT	❑	❑	❑	❑	❑	❑	❑
LABORATORY RPR	❑	❑	❑	❑	❑	❑	❑
LABORATORY HIV	❑	❑	❑	❑	❑	❑	❑
LABORATORY UCG							
LABORATORY LMP							
LABORATORY Other							
Date of Visit							
Annual Visit	❑	❑	❑	❑	❑	❑	❑
Ht. Wt.							
BP							
BC Method							
LABORATORY # Dispensed							
LABORATORY HCT/Hgb	❑	❑	❑	❑	❑	❑	❑
LABORATORY PAP	❑	❑	❑	❑	❑	❑	❑
LABORATORY GC	❑	❑	❑	❑	❑	❑	❑
LABORATORY CT	❑	❑	❑	❑	❑	❑	❑
LABORATORY RPR	❑	❑	❑	❑	❑	❑	❑
LABORATORY HIV	❑	❑	❑	❑	❑	❑	❑
LABORATORY UCG							
LABORATORY LMP							
LABORATORY Other							

Date _____ G _____ P _____ SAB _____ TAB _____ Living Children _____
Date _____ G _____ P _____ SAB _____ TAB _____ Living Children _____
Date _____ G _____ P _____ SAB _____ TAB _____ Living Children _____

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Name _____
Last, First, Middle, Maiden
B.D. _____
Patient I.D. _____

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

IUD Insertion Procedure Chart Form

Age: _____ G: _____ P: _____ LMP: _____ ≤ Day 7 of cycle ❑Yes ❑No Cycle Day: _____
Date of last delivery: _____ C-Section Hx? ❑ Yes ❑ No Lactation: ❑ Yes ❑ No
Next child wanted in how many years? _____, or No more children wanted at this time ❑Prior use of IUD: ❑No ❑Yes
❑ No concerns about pregnancy today ❑ Wants the T380 A IUD as an EC because:_____
Single current partner of what duration: _____years _____months Current Contraception: _____
Reason for choosing IUD over other BCM**:**

❑ If unprotected intercourse in last 5 days understands it is an EC and accepts the risk of pregnancy ❑ N/A
❑ Counseled about both copper and Lng systems and chooses: _____
❑ Has documented Pap/breast exam within past 12 months
❑ No copper, betadine, lidocaine, silicone, polyethylene or Lng allergy
❑ No contraindications to the method
❑ Completed and/or reviewed IUD manufacturer's brochure and/or consent form.
❑ PHSKC FP Consent for Treatment Form signed and placed in chart
❑ Chart labeled with Do Not Discard sticker
❑ Given and confirms reading IUD manufacturer's brochure ❑ Checklist reviewed and no contraindications

Counseling/Evaluation:
❑ Items reviewed
❑ See progress note

Accepts risk of
❑ 1/200 failure the first year and 2% over the life of the IUD.
❑ expulsion risk 5%, 90% symptomatic but 10% none, so important to check for strings after menses.
❑ 1/100 risk of PID from the insertion and 2-5% risk IUD later removed for possible infection.
❑ ectopic pregnancy if failure (30% risk). History of ectopic ❑ No ❑ Yes, signed additional consent
❑ dysmenorrhea, menorrhagia or anemia if T380A ❑ amenorrhea or irregular bleeding if Lng IUD
❑ possible risk of PID if STD contracted
❑ possible 50% chance of SAB if intrauterine pregnancy with IUD in place, and also risk of SAB with removal

Screening tests negative for following tests: ❑ CT (date_____) ❑ GC (date_____) ❑ Pap (date_____)
(if appropriate) ❑ BV (date_____) ❑ HCG (date_____) ❑ hct/hgb (year_____)

Procedure Note Premedication: _____
Bimanual exam results: ❑ AV/AF ❑ midline ❑ RV/RF ❑ small, firm, non-pregnant, symmetric ❑ other: _____
Cervical os cleaned with: ❑ betadine ❑ chlorhexidine ❑ BP_____ ❑ Pulse_____
Tenaculum placed on cervix: ❑ Anterior ❑ Posterior
Sounded depth: ❑ 6.0 cm ❑ 6.5 cm ❑ 7.0 cm ❑ 7.5 cm ❑ 8.0 cm ❑ 8.5 cm ❑ 9.0 cm ❑ Other: _____
Type of IUD: ❑ T380A ❑ Lng 20mcg ❑ other: _____ Lot # _____ Expiration _____

❑ IUD placed at fundus easily without complications
❑ Strings cut to _____ inch length. Client felt cut pieces and taught to feel for strings
❑ Tolerated procedure well
❑ No complications, or _____
❑ Given advice to: call for fever, excess bleeding, missed menses, pain, or if IUD strings not felt.
❑ Advised: no vaginal penetration for 3 to 7 days, backup method for 1 week if not on menses, return to clinic in 6 weeks for exam and sooner if needed for a pregnancy test especially if IUD inserted as an EC method.
❑ Reminded to return every year for an annual exam.
❑ Advised of the date that the device will no longer be effective: _____

NOTES:
❑ Interpreter present and assisted with visit

_____
MA\RN Provider Signature/Title Date

Place Patient Information Sticker Here

MONTHLY INJECTABLE (LUNELLE) CONTRACEPTIVE FLOW SHEET

Date of Last Annual Exam	LMP	BP	WT	Probs. (Y / N)	See Prog. Note? (Y / N)	Today's Injection	Plan
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:_______________________	Next Due:________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:_______________________	Next Due:________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:_______________________	Next Due:________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:_______________________	Next Due:________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:_______________________	Next Due:________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:_______________________	Next Due:________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:_______________________	Next Due:________
Date:			Signature:				

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

MALE FAMILY PLANNING / STD VISIT FORM

Please answer the questions below: ***(Do not urinate before exam!)***

Last Name First	Age:	Who do you live with:
Home phone number: ( )	Message/pager number: ( )	Best time to call:

What is the main reason for your visit today?

Are you allergic to any medicines? ❒ YES ❒ NO *Which ones and describe what happened:*

Do you take medicines, natural remedies, aspirin, or other drugs every day? ❒ YES ❒ NO
List them:

Are you up to date with your immunizations like Rubella and Hepatitis B? ❒ YES ❒ NO ❒ Unknown

Do you use tobacco? ❒ YES ❒ NO How much do you use? _____ How many years? _____
Do you drink alcohol? ❒ YES ❒ NO How often? ❒ daily ❒ weekly ❒ monthly
How many alcoholic drinks do you have? ❒ 1-2 drinks ❒ 3-4 drinks ❒ 5+ drinks

Do you use other drugs (examples: marijuana, cocaine, or IV drugs)? ❒ YES ❒ NO
What do you use? _____ How often? ❒ daily ❒ weekly ❒ monthly

Have you ever had or do you have:
High blood pressure ❒ YES ❒ NO Hepatitis *(turned yellow)* ❒ YES ❒ NO
IV drug use ❒ YES ❒ NO Problems with your kidneys or bladder ❒ YES ❒ NO
Any other serious medical condition ❒ YES ❒ NO

Have you ever had a sexually transmitted disease or genital infection? ❒ YES ❒ NO
(circle the ones you think you might have had)

Chlamydia	Gonorrhea	Herpes	Genital Warts
Syphilis	HIV	Jock itch	Hepatitis B or C

Our services are confidential, however, if you are under the age of 18 and share with us a history of sexual abuse or rape, we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.

How many different sex partners have you had in the last 12 months? _____

Were your partners *(circle):* women men both IV drug user bisexual a partner with multiple sex partners or at risk for HIV or STD

How long have you been with your current sex partner(s)? _____

What type of sex have you had in the past 2 months? *(circle the types)*
Vaginal Oral Anal Other No sex

Are you and your current sex partner(s) using a birth control method *(if any of your sex partners are female)*
If so, what kind?

Do you have symptoms of a genital infection? ❒ YES ❒ NO *(circle the ones you have)*

Rash	Itch/Pain	Pain with urination	Urgent or frequent urination	Stool or anal problems
Bumps	Burning	Sores	Drip/Discharge	Rectal bleeding

Have you had sexual contact with a person with a postive STD test? ❒ NO ❒ YES
Have you had a postive STD test in the last year? ❒ NO ❒ YES
Date of your last sexual contact? _____ Did you use a condom? ❒ YES ❒ NO
Have you used condoms before? ❒ YES ❒ NO
How many hours since you last urinated?_____

Reviewed by: _____

Date: _____

Chart Label

Housing Status: _____

CC: _____

ROS: Constitutional Skin GI GU Breast Neuro CV Resp ENT Eyes Musculoskeletal
_____ Systems reviewed, positive for _____otherwise negative.

PMH/SH/FH:

HPI:

☐ HIV testing requested☐ or recommended ☐ for client, and client agrees

BP _____ WT _____ HT _____

	NL	ABNL	N/A
Skin	☐	☐	☐
Lungs	☐	☐	☐
Heart	☐	☐	☐
Abdomen	☐	☐	☐
Groin lymph nodes	☐	☐	☐
Urethral discharge	☐	☐	☐
Penis shaft	☐	☐	☐
Penis glans	☐	☐	☐
Scrotum	☐	☐	☐
Inguinal canal	☐	☐	☐
Testes descended	☐	☐	☐
Rectal exam	☐	☐	☐
Anal area	☐	☐	☐

Stat Tests Done:

☐ UA dip: LE_____ Nitrate_____
Prot _____ blood_____
Other_____

Education: ECRR Testicular self exam
Smoking: advised to quit/congratulated Hep B
Partner treatment Partner's contraceptive method
Condom use Contraception STD HIV prevention
Abstinence ECP Other:

Literature Given: Smoking HIV STD's
Other: Condoms

Assessment:

Tests Sent: ☐ CT ☐ GC ☐ HSV ☐ HIV
☐ RPR ☐ Hep B ☐ Hep C

Plan:

Circle medications prescribed:

1. Condoms: _____# given
2. Azithromycin 1gm PO
3. Ceftriaxone 125mg 1M given
4. Cefpodoxime 200mg #2 PO
5. Doxycycline 100mg 1 PO BID x 7 days
6. Metronidazole 500mg 4 PO once
7. Acyclovir 400mg 1 PO TID x _____days
8. Hep B vaccine injection site _____ lot#
9. Other:

_____
Signature Date

Chart Label

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

MASTER PROBLEM LIST

Date/Initial	Active Problems	Outcome/Date(s)
	1.	
	2.	
	3.	
	4.	
	5.	
	6.	
	7.	
	8.	
	9.	
	10.	

Init. Signature Signature Init.

Alert/Allergies:

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here

MEDICATION LIST

Date	Drug Name, Dose, Quantity (Put Sticker Here)	Route, Frequency	Signature
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------

Allergy Sticker Here

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here

Date	Drug Name, Dose, Quantity (Put Sticker Here)	Route, Frequency	Signature
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------
----------	----------	----------	----------

Pregnancy Screening

Age: _____ Gravida: _____ Para: _____ SAB: _____ TAB: _____ Living children: _____

LMP:_____ LNMP: _____ Date last pregnancy ended: _____ Last Pap: _____

Last BCM used : _____ Last UPIC: _____ Breastfeeding: ☐ Yes ☐ No

Complications with previous pregnancies: _____

Allergies: _____ Daily medications taken: _____

Serious medical problems:_____

Pregnancy Sx present? _____ Genital infection Sx present?_____

Ectopic risk factors?_____ STD risk factors?_____

UCG: ☐ positive ☐ negative Planned Pregnancy? ☐ Yes ☐ No Pregnancy Options Discussed? ☐ Yes ☐ No

Discussed decision/plans: _____

_____

Referrals: ☐ Abortion Facility ☐ DSHS / Application Worker ☐ EC Rx
☐ Family Planning ☐ Hospital / ER ☐ Maternity Screening / Support Services
☐ PHN ☐ PMD ☐ Provider Visit in Clinic Today
☐ Social Worker ☐ WIC ☐ Other _____

Assess as appropriate: Provide Counseling/Education, depending on decision

☐ Obstetric care services ☐ Hot tubs, saunas ☐ Substance use / medications
☐ Abortion services ☐ Rubella, Hep B, other
☐ Adoption services ☐ Alcohol

(check box if done)
☐ Smoking
☐ X-rays
☐ Domestic Violence
☐ Animals in household

Vitamins with folate ☐ discussed ☐ given ☐ prescription _____

Handouts ☐ No ☐ Yes_____

Signature_____ Date _____

Exam: Uterus size: _____ BP: _____ Weight: _____

Tests: ☐ CT ☐ GC ☐ Pap ☐ Wet mount: BV_____ trich _____ yeast _____

Notes: _____

_____

_____

Signature: _____ Date: _____

Public Health – Seattle & King County Verification of Pregnancy

_____ was seen on _____
(Name) (Date)

The presence of a pregnancy of _____ menstrual weeks gestation is presumed on the basis of the following:

Last Menses (LMP): _____ Pregnancy test (UCG) ☐ positive EDD: _____

Please start Medicaid coverage as of _____ First Steps referral on _____

Signature:_____ Date: _____

(see back for address & phone number)

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Distribution:
1) Chart Copy (white)
2) Provider Copy (yellow)
3) CSO/Client Copy (white)

CS 13.22.15 11/00
PH-0070 (4/05)
1202M

Name_____
Last First Middle Maiden

DOB _____ Patient I.D._____

Address _____ Phone #_____

Pregnancy Screening

Age: _____ Gravida: _____ Para: _____ SAB: _____ TAB: _____ Living children: _____

LMP:_____ LNMP: _____ Date last pregnancy ended: _____ Last Pap: _____

Last BCM used : _____ Last UPIC: _____ Breastfeeding: ☐ Yes ☐ No

Complications with previous pregnancies: _____

Allergies: _____ Daily medications taken: _____

Serious medical problems:_____

Pregnancy Sx present? _____ Genital infection Sx present?_____

Ectopic risk factors?_____ STD risk factors?_____

UCG: ☐ positive ☐ negative Planned Pregnancy? ☐ Yes ☐ No Pregnancy Options Discussed? ☐ Yes ☐ No

Discussed decision/plans: _____

_____

Referrals: ☐ Abortion Facility ☐ DSHS / Application Worker ☐ EC Rx
☐ Family Planning ☐ Hospital / ER ☐ Maternity Screening / Support Services
☐ PHN ☐ PMD ☐ Provider Visit in Clinic Today
☐ Social Worker ☐ WIC ☐ Other _____

Assess as appropriate: Provide Counseling/Education, depending on decision

☐ Obstetric care services ☐ Hot tubs, saunas ☐ Substance use / medications
☐ Abortion services ☐ Rubella, Hep B, other
☐ Adoption services ☐ Alcohol

(check box if done)
☐ Smoking
☐ X-rays
☐ Domestic Violence
☐ Animals in household

Vitamins with folate ☐ discussed ☐ given ☐ prescription _____

Handouts ☐ No ☐ Yes_____

Signature_____ Date _____

Exam: Uterus size: _____ BP: _____ Weight: _____

Tests: ☐ CT ☐ GC ☐ Pap ☐ Wet mount: BV_____ trich _____ yeast _____

Notes: _____

_____

_____

Signature: _____ Date: _____

Public Health – Seattle & King County Verification of Pregnancy

_____ was seen on _____
(Name) (Date)

The presence of a pregnancy of _____ menstrual weeks gestation is presumed on the basis of the following:

Last Menses (LMP): _____ Pregnancy test (UCG) ☐ positive EDD: _____

Please start Medicaid coverage as of _____ First Steps referral on _____

Signature:_____ Date: _____

(see back for address & phone number)

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Distribution:
1) Chart Copy (white)
2) Provider Copy (yellow)
3) CSO/Client Copy (white)

CS 13.22.15 11/00
PH-0070 (4/05)
1202M

Name_____
Last First Middle Maiden

DOB _____ Patient I.D._____

Address _____ Phone #_____

Health Department Site Exam Done at: (check below)

- ☐ **Auburn Public Health Center** **206-296-8400**
  20 Auburn Avenue, Auburn, WA 98002
- ☐ **Columbia Public Health Center** **206-296-4650**
  4400 37th Avenue South, Seattle, WA 98118
- ☐ **Downtown Public Health Center** **206-296-4755**
  2124 Fourth Avenue, Seattle, WA 98121
- ☐ **Eastgate Public Health Center** **206-296-4920**
  14350 Southeast Eastgate Way, Bellevue, WA 98007
- ☐ **Federal Way Public Health Center** **206-296-8410**
  33431 13th Place South, Federal Way, WA 98003
- ☐ **Kent Public Health Center** **206-296-4500**
  1404 South Central Avenue, Suite 112, Kent, WA 98032
- ☐ **Kent Teen Clinic** **206-296-7450**
  613 West Gowe, Kent, WA 98032
- ☐ **North Public Health Center** **206-296-4765**
  10501 Meridian Avenue North, Seattle, WA 98133
- ☐ **Northshore Public Health Center** **206-296-9787**
  10808 Northeast 145th Street, Bothell, WA 98011
- ☐ **Renton Public Health Center** **206-296-4700**
  3001 Northeast Fourth, Renton, WA 98011
- ☐ **White Center Public Health Center** **206-296-4620**
  10821 Eighth Avenue Southwest, Seattle, WA 98146

CSO / DSHS Offices

☐ **Belltown**
2106 Second Avenue
Seattle, WA 98101
206-956-3353 (Main)
206-956-3327 (Nurse)

☐ **Burien**
15811 Ambaum Blvd. S.W.
Burien, WA 98168
206-439-5300 (Main)
206-439-6526 (Nurse)

☐ **Capitol Hill**
1700 East Cherry
Seattle, WA 98122
206-568-5500 (Main)
206-568-5531 (Nurse)

☐ **Federal Way**
616 South 348th Street
Federal Way, WA 98063
253-838-2800 (Main)
253-835-2829 (Nurse)

☐ **King Eastside**
14360 S.E. Eastgate Way
Bellevue, WA 98007
425-649-4000 (Main)
425-649-4373 (Nurse)

☐ **King North**
907 Northwest Ballard Avenue
Seattle, WA 98107
206-789-5200 (Main)
206-545-7782 (Nurse)

☐ **King South**
25316 74th Avenue South
Kent, WA 98035
253-872-2145 (Main)
253-872-6097 (Nurse)

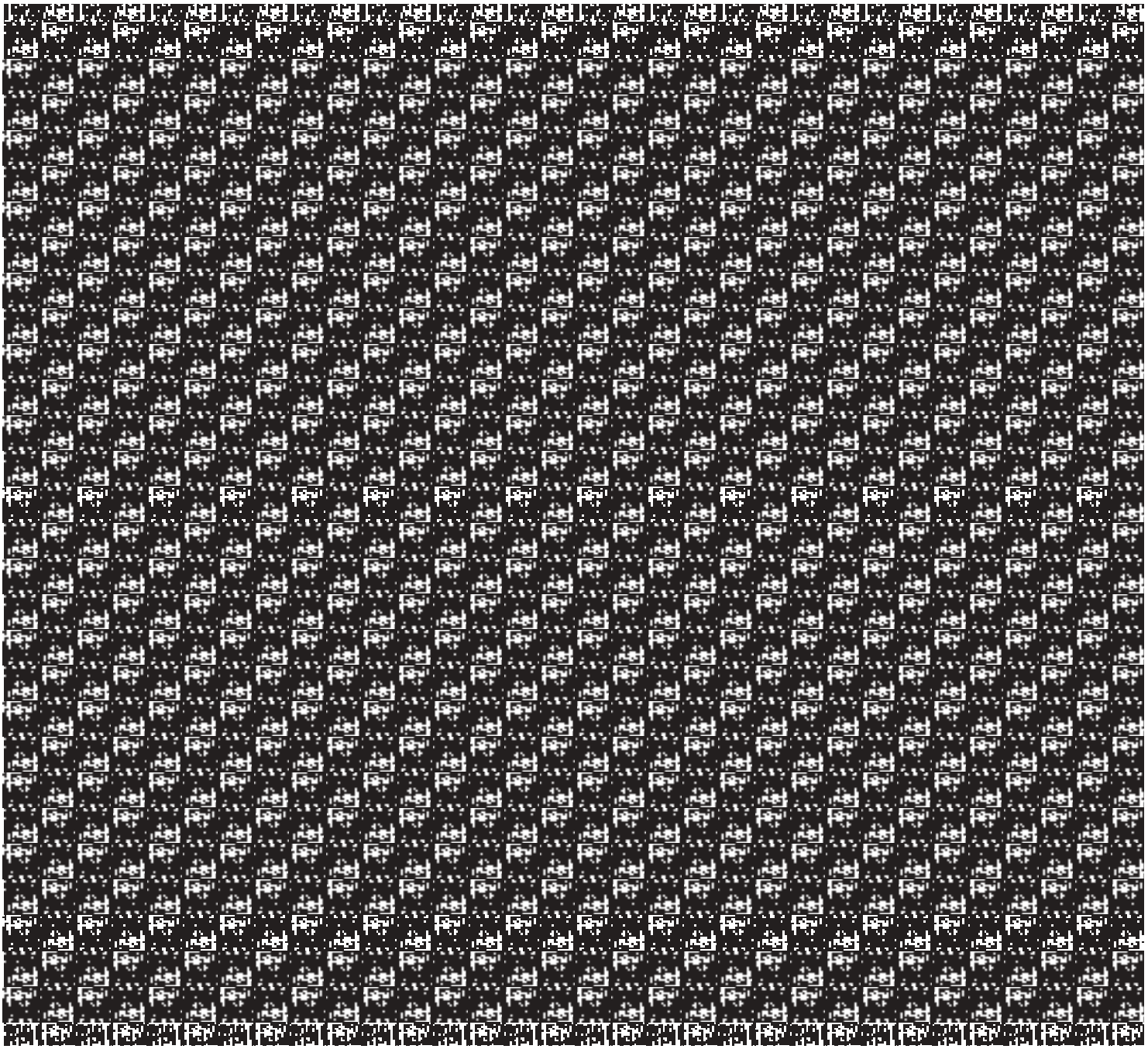
☐ **Lake City**
11536 Lake City Way N.E.
Seattle, WA 98125
206-368-7200 (Main)
206-368-7176 (Nurse)

☐ **Rainier**
3600 South Graham Street
Seattle, WA 98118
206-760-2000 (Main)
206-760-2314 (Nurse)

☐ **Renton**
500 S.W. 7th Street, #B
Renton, WA 98055
425-793-5700 (Main)
425-793-5777 (Nurse)

☐ **West Seattle**
Suite 300
4045 Delridge Way S.W.
Seattle, WA 98106
206-933-3300 (Main)
206-923-4940 (Nurse)

Pregnancy Screening



Public Health – Seattle & King County Verification of Pregnancy

_____ was seen on _____
(Name) (Date)

The presence of a pregnancy of _____ menstrual weeks gestation is presumed on the basis of the following:

Last Menses (LMP): _____ Pregnancy test (UCG) ☐ positive EDD: _____

Please start Medicaid coverage as of _____ First Steps referral on _____

Signature: _____ Date: _____

(see back for address & phone number)

Distribution:
1) Chart Copy (white)
2) Provider Copy (yellow)
3) CSO/Client Copy (white)

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

CS 13.22.15 11/00
PH-0070 (4/05)
1202M

Name _____
Last First Middle Maiden

DOB _____ Patient I.D. _____

Address _____ Phone # _____

Health Department Site Exam Done at: (check below)

- ☐ **Auburn Public Health Center** **206-296-8400**
  20 Auburn Avenue, Auburn, WA 98002
- ☐ **Columbia Public Health Center** **206-296-4650**
  4400 37th Avenue South, Seattle, WA 98118
- ☐ **Downtown Public Health Center** **206-296-4755**
  2124 Fourth Avenue, Seattle, WA 98121
- ☐ **Eastgate Public Health Center** **206-296-4920**
  14350 Southeast Eastgate Way, Bellevue, WA 98007
- ☐ **Federal Way Public Health Center** **206-296-8410**
  33431 13th Place South, Federal Way, WA 98003
- ☐ **Kent Public Health Center** **206-296-4500**
  1404 South Central Avenue, Suite 112, Kent, WA 98032
- ☐ **Kent Teen Clinic** **206-296-7450**
  613 West Gowe, Kent, WA 98032
- ☐ **North Public Health Center** **206-296-4765**
  10501 Meridian Avenue North, Seattle, WA 98133
- ☐ **Northshore Public Health Center** **206-296-9787**
  10808 Northeast 145th Street, Bothell, WA 98011
- ☐ **Renton Public Health Center** **206-296-4700**
  3001 Northeast Fourth, Renton, WA 98011
- ☐ **White Center Public Health Center** **206-296-4620**
  10821 Eighth Avenue Southwest, Seattle, WA 98146

CSO / DSHS Offices

☐ **Belltown**
2106 Second Avenue
Seattle, WA 98101
206-956-3353 (Main)
206-956-3327 (Nurse)

☐ **Burien**
15811 Ambaum Blvd. S.W.
Burien, WA 98168
206-439-5300 (Main)
206-439-6526 (Nurse)

☐ **Capitol Hill**
1700 East Cherry
Seattle, WA 98122
206-568-5500 (Main)
206-568-5531 (Nurse)

☐ **Federal Way**
616 South 348th Street
Federal Way, WA 98063
253-838-2800 (Main)
253-835-2829 (Nurse)

☐ **King Eastside**
14360 S.E. Eastgate Way
Bellevue, WA 98007
425-649-4000 (Main)
425-649-4373 (Nurse)

☐ **King North**
907 Northwest Ballard Avenue
Seattle, WA 98107
206-789-5200 (Main)
206-545-7782 (Nurse)

☐ **King South**
25316 74th Avenue South
Kent, WA 98035
253-872-2145 (Main)
253-872-6097 (Nurse)

☐ **Lake City**
11536 Lake City Way N.E.
Seattle, WA 98125
206-368-7200 (Main)
206-368-7176 (Nurse)

☐ **Rainier**
3600 South Graham Street
Seattle, WA 98118
206-760-2000 (Main)
206-760-2314 (Nurse)

☐ **Renton**
500 S.W. 7th Street, #B
Renton, WA 98055
425-793-5700 (Main)
425-793-5777 (Nurse)

☐ **West Seattle**
Suite 300
4045 Delridge Way S.W.
Seattle, WA 98106
206-933-3300 (Main)
206-923-4940 (Nurse)

FOR OFFICE USE ONLY	
Requestor's Number	Date Received

Department of Health

FORMS AND PUBLICATIONS REQUEST

NOTE: This is your Shipping Label – Use complete street address (UPS will not deliver to a P.O. Box).

Name/Requestor	Telephone	Date
Name of Organization		Internet E-mail Address
Shipping Address		
City	State	Zip

Does Your Organization have a WIC Program? ☐ Yes ☐ No

No.	Forms or Publication Number	Title	Quantity Requested	Quantity Shipped	Back Order
1	**930-101 4/02**	**FP Methods Flip Chart Brochure, English**			
2	**930-101**	**FP Methods Flip Chart Brochure, Spanish**			
3					
4					
5					
6					
7					
8					
9					
10					
11					

INSTRUCTIONS: Please put the publications and forms you are requesting in numerical order by the DOH number. Include both the form and pub number **and** the title. Order all items in **each** amounts. Your order will be filled to the nearest packaged amount.

Requestor's name and telephone number **must** be filled in (in case we have questions about your order.)

For orders that DO NOT involve a payment: Send this fully completed form to Department of Health, PO Box 47845, Olympia, WA 98504-7845. **Faxed orders are accepted at (360) 664-2929**. Telephone orders are not accepted. **Do not re-order items that are back ordered.** They will be sent to you as soon as new stock is available.

For orders that include payment: Send this fully completed form and check to DOH Revenue Section, PO Box 1099, Olympia, WA 98507-1099.

If you have any questions, please contact the DOH Warehouse at (360) 586-9046.

Revised: 10/25/05

DISTRIBUTION CENTER
INVENTORY WITHDRAWAL

Org Unit			Project		

Fax: 206-296-0185
Phone: 206-296-4690

No. C
(**Warehouse Use Only**)

Org Unit Title **Project Title** **Date**

NOTE: CATALOG NUMBERS MUST BE LISTED FOR ALL ITEMS

ITEM #	QUANTITY ORDERED	UNIT	CATALOG NUMBER 7 digits		ITEM DESCRIPTION
1		PK	450	0546	Cuentanos!
2		PK	450	0548	Your life. Your style. Your birth control.
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					

Date received **Person to Contact** **Phone Number** **Authorized Signature**

Update: 8.15.05

DISTRIBUTION CENTER
INVENTORY WITHDRAWAL

Org Unit			Project		

Fax: 206-296-0185
Phone: 206-296-4690

No. C
(**Warehouse Use Only**)

Org Unit Title **Project Title** **Date**

NOTE: CATALOG NUMBERS MUST BE LISTED FOR ALL ITEMS

ITEM #	QUANTITY ORDERED	UNIT	CATALOG NUMBER 7 digits		ITEM DESCRIPTION
1		PD	450	0343	Female FP Health History Form, CS 13.22.61
2		PK	450	0493	Female FP/STD Visit Form, CS 13.22.89
3		PK	450	0474	Male FP/STD Visit Form, CS 13.22.74
4		PK	450	0468	Lab Slip Region X, Infertility Project
5		PD	450	0321	Pregnancy Screening Form, CS 13.22.15 (NCR)
6		PD	450	0453	FP CSO Visit Note Form, CS 13.22.98
7		PK	450	0024	Consultation & Referral Request, CS 13.22.95 (NCR)
8		PD	450	0320	FP Consent Form, CS 13.22.13
9		PD	450	0319	FP Flow Sheet, CS 13.22.11
10		PK	450	0492	ECRR Flow Sheet, CS 13.22.88
11		PK	450	0496	Menstrual Diary Reminder Card, CS 13.22.92
12		PK	450	0198	Medication List, CS 13.22.96
13		PD	450	0249	Master Problem List, CS 13.22.97
14		PD	450	0248	PHSKC Progress Notes, CS 13.19.29
15		PD	450	0195	Prescription Pad, CS 13.11.1
16		PK	450	0259	Laboratory Report, CS 13.19.65
17		PD	450	0290	Triage Form, CS 13.19.109
18		PK	450	0468	Lab Slip Region X, Infertility Project
19		BX	305	0472	Unique Retention Labels
20		BX	305	0473	Allergy Labels
21					
22					
23					

Date received **Person to Contact** **Phone Number** **Authorized Signature**

Shipping Address: _____

DISTRIBUTION CENTER
INVENTORY WITHDRAWAL

Org Unit			Project		

Fax: 206-296-0185
Phone: 206-296-4690

No. C
(Warehouse **Use Only**)

Org Unit Title **Project Title** **Date**

NOTE: CATALOG NUMBERS MUST BE LISTED FOR ALL ITEMS

ITEM #	QUANTITY ORDERED	UNIT	CATALOG NUMBER 7 digits		ITEM DESCRIPTION
1		PK	450	0514	When You Choose the Pill
2		PK	450	0515	When You Choose Depo
3		PK	450	0520	When You Choose the IUD
4		PK	450	0521	When You Choose the Condom
5		PK	450	0522	When You Choose EC
6		PK	450	0525	When You Choose the Ring
7		PK	450	0526	When You Choose the Patch
8		PK	450	0527	When You Choose Sterilization
9		PK	450	0528	When You Choose the Pill (Vietnamese)
10		PK	450	0529	When You Choose the Pill (Spanish)
11		PK	450	0530	When You Choose Depo (Vietnamese)
12		PK	450	0531	When You Choose Depo (Spanish)
13		PK	450	0542	When You Choose EC (Spanish)
14		PK	450	0543	When You Choose EC (Vietnamese)
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					

Date received **Person to Contact** **Phone Number** **Authorized Signature**

DISTRIBUTION CENTER
INVENTORY WITHDRAWAL

Org Unit			Project		

Fax: 206-296-0185
Phone: 206-296-4690

No. C
(**Warehouse Use Only**)

Org Unit Title **Project Title** **Date**

NOTE: CATALOG NUMBERS MUST BE LISTED FOR ALL ITEMS

ITEM #	QUANTITY ORDERED	UNIT	CATALOG NUMBER 7 digits		ITEM DESCRIPTION
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					

Date received **Person to Contact** **Phone Number** **Authorized Signature**

Mail to: Department of Health, STD/TB Services Rev. October 27, 2005
PO Box 47842, Olympia, WA 98504-7842
Telephone: (360) 236-3460 FAX 236-3470

STD Materials List **(Allow 2 weeks for delivery)**

ATTENTION: _____DATE_____

ORGANIZATION_____PHONE_____

STREET (UPS WILL NOT DELIVER TO POB)_____

CITY_____STATE_____ZIP_____

_

FOR PUBLIC USE ONLY: Washington State law requires the STD pamphlets used for the general public emphasize the importance of abstinence, sexual fidelity and the avoidance of substance abuse.

NUMBER	TITLE	B/O	ENGLISH	SPANISH
347-005	ABOUT CHLAMYDIA			
347-004	FACTS OF LICE			
347-006	GENITAL HERPES			
347-030	GENITAL WARTS			
347-032	MANY TEENS ARE SAYING NO			
347-012	SCABIES			
347-002	SEXUALLY TRANSMITTED DISEASES			
347-042	¡QUÉ PESADILLA! (PREGNANCY/STD) SPANISH ONLY			
347-026SP	¡ALARMA! **(PID) SPANISH ONLY**			
347-031SP	SUEÑOS **(SYPHILIS) SPANISH ONLY**			
347-033SP	SIN SÍNTOMAS **(CHLAMYDIA) SPANISH ONLY**			
347-034SP	LA VERGÜENZA **(HERPES) SPANISH ONLY**			
347-043SP	¡NO ES CIERTO! **(SUBSTANCE ABUSE & STD) SPANISH ONLY**			
347-045SP	LA LOTERÍA DEL DESTINO **(WARTS) SPANISH ONLY**			
347-007	VIRAL HEPATITIS			
347-331	GOT LUCKY? GET TESTED FOR CHLAMYDIA			
REPRINT	**SEVENTEEN MAGAZINE** CHLAMYDIA/PID INVISIBLE STDS (LILAC)			
REPRINT	**SEVENTEEN MAGAZINE** STD UPDATE (DK. GREEN)			
REPRINT	**SEVENTEEN MAGAZINE** VIRGINITY (IVORY)			
REPRINT	**SEVENTEEN MAGAZINE** THE HAZARDS OF EARLY SEX (BLUE)			
REPRINT	CHLAMYDIA POSTER 8 1/2" X 11"			
REPRINT	KNOW STD CURRICULUM (1 per teacher)			
REPRINT	STD CHECKLIST			

MATERIALS ON THIS SIDE OF THE ORDER FORM ARE FOR THE GENERAL PUBLIC

SEE OTHER SIDE OF ORDER FORM FOR PAMPHLETS TO BE USED FOR STD PATIENTS

FOR PATIENT USE ONLY: The pamphlets listed are to be used by clinicians for the management and education of patients at risk for STDs. They are not for distribution to the general public.

NUMBER	AMOUNT	B/0	TITLE
347-003			AIDS
347-010			BACTERIAL VAGINOSIS
347-015			CANDIDIASIS
347-016			CHLAMYDIA
347-017			GENITAL HERPES
347-009			GENITAL WARTS
347-019			GONORRHEA
347-020			NGU - NONGONOCOCCAL URETHRITIS
347-011			PID - PELVIC INFLAMMATORY DISEASE
347-023			PUBIC LICE
347-024			SCABIES
347-025			SYPHILIS
347-008			TRICHOMONAS
347-027			UNCOMMON STD (LGV, GI, CHANCROID)
347-001			CONDOM PACKET (ENGLISH) CONDOMS NOT INCLUDED)
347-001			CONDOM PACKET (SPANISH) (CONDOMS NOT INCLUDED)
347-330			STD POSTER - PHOTOGRAPHS
FEDERAL			CONDOMS AND STD PAMPHLET
REPRINT			CHLAMYDIA (MEN'S FITNESS) (MELON/ORANGE)
REPRINT			BEWARE OF HPV (MEN'S FITNESS) (BUFF)
REPRINT			DANGEROUS SEX (MUSCLE AND FITNESS) (YELLOW)
REPRINT			SEX WHILE INTOXICATED (SEVENTEEN) (LT. GREEN)
REPRINT			WARTS (SEVENTEEN) (TAN)
REPRINT			SCARY FACTS ABOUT STD (SEVENTEEN) (PINK)
REPRINT			CONDOM ARTICLE (ESSENCE) (TURQUOISE)

FOR CLINICIANS ONLY

347-022			STD TREATMENT GUIDELINES 1998
REPRINT			STD REFERENCE GUIDE 1998 (LAMINATED)
REPRINT			VAGINAL WET PREPS (LAMINATED)
REPRINT			CDC STD MEDICAL & LAB SERVICES GUIDELINES 2002
347-226			STD PARTNER NOTIFICATION: HOW TO TELL YOUR PARTNER
347-227			STD PARTNER NOTIFICATION: QUESTIONS & ANSWERS
347-228			STD PARTNER NOTIFICATION: WHAT DOES IT MEAN TO BE EXPOSED
347-006			CONFIDENTIAL STD CASE REPORTS____2 PART ___ 3 PART CASE REPORTS W/ENVELOPES